

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4449

CERTIFICATE OF DEATH

04438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		b. COUNTY Kent	
c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Emily	Last Ahles
4. DATE OF DEATH	Month April	Day 26	Year 1959
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1902
9. AGE (In years less birthday) 57 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Massachusetts	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Judian Francis Perry	14. MOTHER'S MAIDEN NAME Unknown	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT deceased	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) <u>Coronary artery disease</u> ? years lying cause lost. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>BronchoPneumonia, resolving</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-20-</u> , 19 <u>59</u> , to <u>4-25-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-25-</u> , 19 <u>59</u> , and that death occurred at <u>1:00 pm</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>HARRY PAUL ROSS</u> M.D. DATE SIGNED 4-26-59			
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.		203 North Queen Street Chestertown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery	22d. LOCATION (City, town, or county) Chestertown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>	ADDRESS Chestertown, Md.	24a. REC'D BY REGISTRAR DATE APR 29 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

2010 COMMERCIAL-2010 TRANSFRAMO STATE CHARTER

CERTIFICATE OF DEATH

80-20

DECEASED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4460

CERTIFICATE OF DEATH

04439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BRENDA		First	Middle	4. DATE OF DEATH ASHLEY	Month April	Day 4,	Year 1959
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1958	9. AGE (In years lost birthday) yrs. 5	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Baby		11. BIRTHPLACE (State or foreign country) Wilmington Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Ashley		14. MOTHER'S MAIDEN NAME Rosie Sudler		Address Millington, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT James Ashley		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.6 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
20c. TIME OF INJURY Hour p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Smyrna	(County) Del.
21. I certify that I attended the deceased from alive on		APRIL 3, 1959		to APRIL 4, 1959, that I last saw the deceased and that death occurred at 4:00 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 117 W. COMMERCE ST Smyrna, Del.	
ACTUAL SIGNATURE HAROLD J. LAGNER		M.D.				DATE SIGNED APRIL 6, 1959	
PHYSICIAN'S NAME (Type) HAROLD J. LAGNER							
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22e. DATE THEREOF April 6, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Riley's Neck Cemetery		22d. LOCATION (City, town, or county) Rural Millington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur & Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4450

CERTIFICATE OF DEATH

04440

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Kent	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Annie	Middle Carter	4. DATE OF DEATH Month 4 Day 12 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/81			
9. AGE (In years from last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? USA America						
13. FATHER'S NAME Harry Gadd		14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Bertha Gears, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH Immediate.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, lost. (b) DUE TO						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Cholecystitis + Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <u>Mar 29, 1957</u> to <u>Apr 12, 1957</u> that I last saw the deceased alive on <u>Apr 12, 1957</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Chestertown Md.		DATE SIGNED 4-13-59		
ACTUAL SIGNATURE <u>A. T. Keay</u>		PHYSICIAN'S NAME (Type) <u>A. T. Keay, Jr. Md</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/15/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Baptist Chapel Church Hill	22d. LOCATION (City, town, or county) Rock Hall	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Sane		24a. REC'D BY REGISTRAR APR 17 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Keay			

MANUFACTURER'S STATE INSURANCE COMPANY, INC.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4451

CERTIFICATE OF DEATH

04441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
3. NAME OF DECEASED (Type or print) BARTUS		d. STREET ADDRESS /	
4. DATE OF DEATH April		Month 22	Day Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1885
9. AGE (In years 10th birthday) 73 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Carter	
14. MOTHER'S MAIDEN NAME Susan Cannon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH 12 days	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10/59</u> , 19, to <u>4/22/59</u> , 19, that I last saw the deceased alive on <u>4/22/59</u> , 19, and that death occurred at <u>7:35 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Robert W. Farr</u> PHYSICIAN'S NAME (Type) ROBERT W. FARR		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 4/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL <u>4/25/59</u>		22b. DATE THEREOF Wesley Chapel	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Rock Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar S. Lane C. Bush Hill		24a. REC'D BY REGISTRAR DATE APR 28 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur & Thrua	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4452

CERTIFICATE OF DEATH

014442

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>KENT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN 1b <u>072</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
3. NAME OF DECEASED (Type or print) <u>Oliver</u>		First <u>A</u>	Middle <u>ADA</u>
4. DATE OF DEATH <u>Month April Day 2 Year 1959</u>		5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 25 1887</u>	
9. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		10. AGE (in years lost birthday) <u>77 yrs.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>N. A.</u>	
13. FATHER'S NAME <u>Frank H. Mariner</u>		14. MOTHER'S MAIDEN NAME <u>Emma Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>330X</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT <u>Mrs. Lois Sherman</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>High blood pressure</u> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
19. WAS AUTOPSY PERFORMED? <u>NO</u>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Chestertown</u> (County) <u>Md</u> (State) <u>Md</u>	
21. I certify that I attended the deceased from <u>4-2</u> , 19 <u>59</u> , to <u>4-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>59</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>4-2-59</u>			
ACTUAL SIGNATURE <u>A.C. Dick</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial April 5-59</u>	
22b. DATE THEREOF <u>April 5-59</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Wesley Chapel</u>	
22d. LOCATION (City, town, or county) <u>Rock Hall</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>APR 8 59</u>	
ADDRESS <u>Church Hill Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 8 & 9, Film G-1, 4/10/59, 4461											
CERTIFICATE OF DEATH											
Reg. Dist. No. 04443											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Betterton			c. LENGTH OF STAY IN 1b Adult Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Betterton, Md.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home			d. STREET ADDRESS Route 1, Worton, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Emma		Middle Hance		4. DATE OF DEATH Month April 2, 1959					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug, 2, 1879?		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Kent Co. Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Perry Wright				14. MOTHER'S MAIDEN NAME Emma White							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [For, no, or unknown] NO			16. SOCIAL SECURITY NO none			17. INFORMANT William Hance			Address Worton, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage</i> INTERVAL BETWEEN DUE TO <i>hypertension + arteriosclerosis</i> ONSET AND DEATH 2 hours 30x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) <i>hypertension + arteriosclerosis</i> 5 years. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arthritis</i>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1956</u> , to <u>Sept 2, 1959</u> , that I last saw the deceased alive on <u>Feb 15, 1959</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>Florence George Joyce</i> M.D. Worton Maryland DATE SIGNED <u>4/13/59</u>											
22a. BURIAL, CREMATION, BURIAL (Specify) Burial			22b. DATE THEREOF 4/5/59			22c. NAME OF CEMETERY OR CREMATORIUM Colemans Cemetery			22d. LOCATION (City, town, or county) Colemans, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Walker</i>			ADDRESS Chestertown, Md.			24a. REC'D BY REGISTRAR DATE APR 6 '59			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knapp</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4453

CERTIFICATE OF DEATH

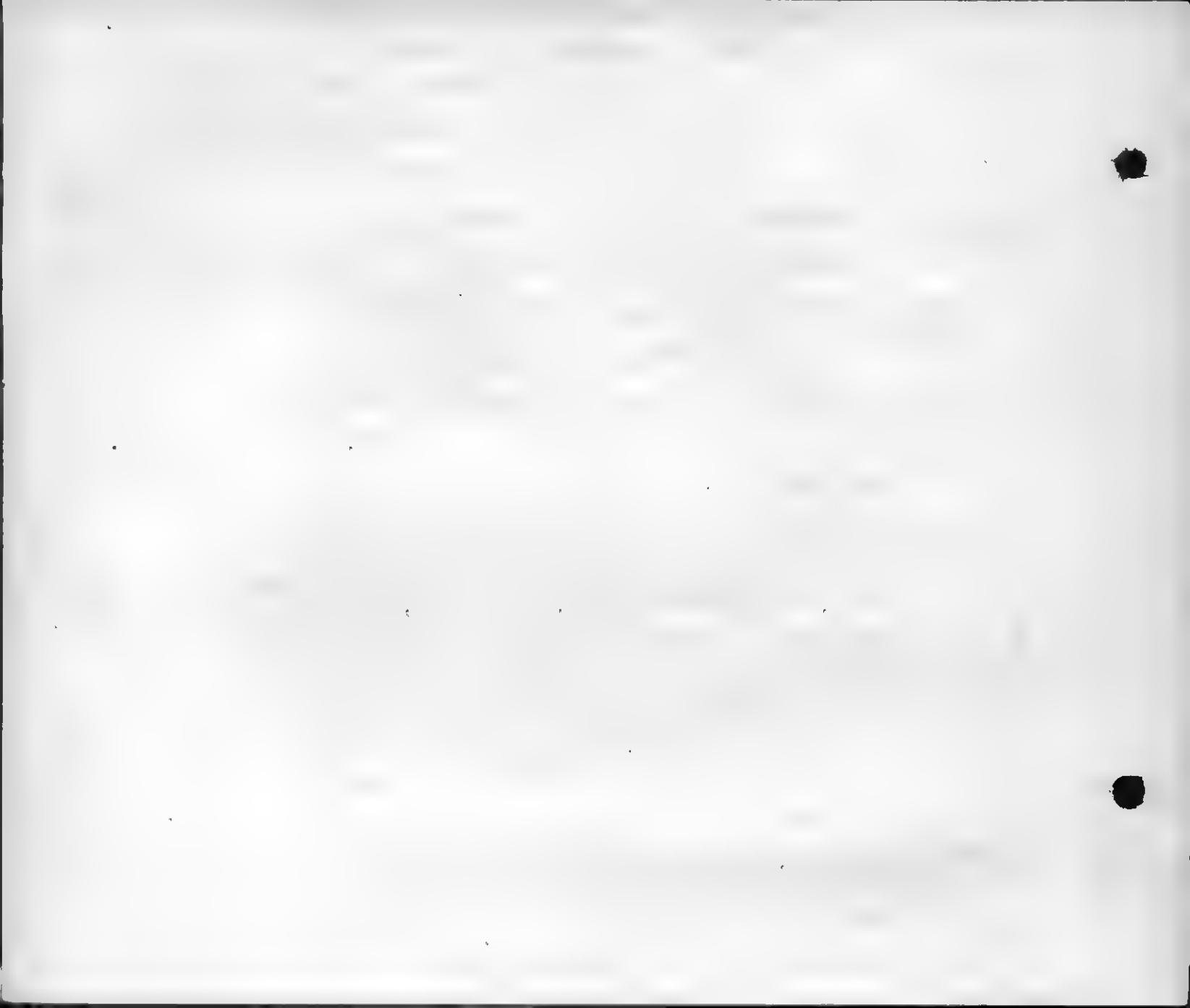
04444

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesterstown		c. LENGTH OF STAY IN lb 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arminta		First (Minnie)	Middle	Last Higgins	4. DATE OF DEATH April	Month 25	Day 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1889	9. AGE (In years lost birthday) 69 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Elburn		14. MOTHER'S MAIDEN NAME Harriett Beck		Address Hospital Records, Chestertown, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records, Chestertown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost (b) Prolonged stay in bed DUE TO (c) Generalized arteriosclerosis, Auricular fibrillation with failure, diabetes mellitus, nephritis, colloid goiter and amputation of right leg due to gangrene	
						INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While Not while p. m. of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30, 1959, to 4/25/1959, that I last saw the deceased alive on 4/25, 1959, and that death occurred at 8:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert W. Farr</i> M.D. ADDRESS (Street, city or town, state) ROBERT W. FARR						DATE SIGNED 4/25/59	
22a. BURIAL, CREMATION: REMOVAL (Specify) 4/25/59		22b. DATE THEREOF 4/25/59		22c. NAME OF CEMETERY OR CREMATORIAL Westview Cemetery		22d. LOCATION (City, town, or county) Rock Hall, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar J. Lane</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE <i>Armen & Krause</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

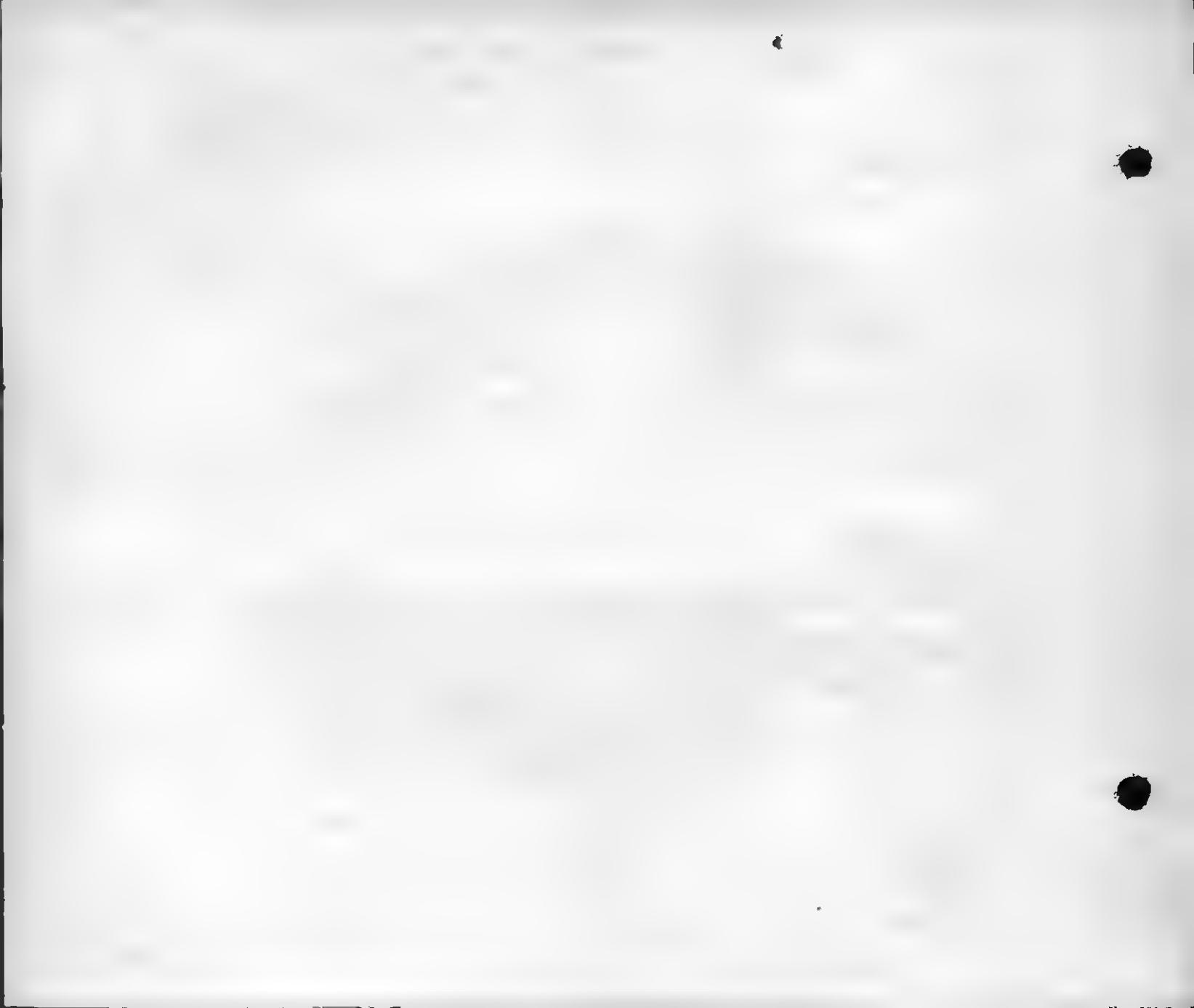
11445

4454

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland				b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 35 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's				d. STREET ADDRESS 1/ 618 High Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Jane	Last Hiltner	4. DATE OF DEATH	Month April	Day 14	Year 1959				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1885		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Howell				14. MOTHER'S MAIDEN NAME Margaret Clough							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Charles H. Callaway		Address Magnolia, Deleware					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 232X DUE TO Cerebral vascular thrombosis								INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized Arteriosclerosis (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial infarction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 4-10-1959, 19, to 4-14-1959, 19, that I last saw the deceased alive on 4-14-1959, 19, and that death occurred at 6:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Harry Paul Ross</i> M.D. ADDRESS (Street, city or town, state) HARRY PAUL ROSS, M.D. Chestertown, Maryland DATE SIGNED 4-15-1959											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hollywood Cem.		22d. LOCATION (City, town, or county) Harrington, Del.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR APR 20 '59 DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tolson</i>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4462

CERTIFICATE OF DEATH

04446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) RFD at home (Cliff's City)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles W. Kirby		First	Middle
4. DATE OF DEATH	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1887
9. AGE (In years from birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Liverman	11. KIND OF BUSINESS OR INDUSTRY (oystering - Fishing)	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Robert Lee Kirby	14. MOTHER'S MAIDEN NAME Ida L. Neil	12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no	16. SOCIAL SECURITY NO.	17. INFORMANT James Kirby	Address RFD (Cliff's City Chestertown, Md.)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 3 [REDACTED]	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Mental confusion		same	
(c) DUE TO Arterie sclerosis		same	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 6, 1959, to April 27, 1959, that I last saw the deceased alive on April 27, 1959, and that death occurred at 2:45 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED ACTUAL SIGNATURE Robert W. Farr Apr. 28, 1959			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 4/30/59	22c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery
22d. LOCATION (City, town, or county) Chestertown, Md. (State)		23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells	
24a. REC'D BY REGISTRAR DATE APR 30 '59		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PHYSICIAN: The law requires a physician to execute

order

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4455

CERTIFICATE OF DEATH

04447

Reg. Dist. No.

1 Within 24 hours after death or after removal from the place of death, the attending physician or other medical practitioner, or the funeral director, or the registrar, or any other person authorized by law, may be retained to file this certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or within any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b RURAL and give nearest town		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Kent		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		d. STREET ADDRESS Piney Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Edward	Middle Thomas	Last Long	4. DATE OF DEATH Apr. 17 /59	Month Apr.	Day 17	Year /59		
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12 1892		9. AGE (In years last birthday) 0 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours Min		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Sea Food		11. BIRTHPLACE (State or foreign country) Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles Long			14. MOTHER'S MAIDEN NAME Laura Jones							
15. a. DECEASED EVER IN U. S. ARMED FORCES? Unknown		16. SOCIAL SECURITY NO 220-05-1857		17. INFORMANT Mrs. Rachel Long Rock Hall, Md.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> INTERVAL BETWEEN DUE TO <u>450.0</u> ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Renal insufficiency</u> <u>months</u> (c) <u>Generalized arteriosclerosis</u> <u>years</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>Feb 1959</u> to <u>4-16 1959</u> , that I last saw the deceased alive on <u>4-16 1959</u> , and that death occurred at <u>Rock Hall</u> , from the causes and on the date stated above.									ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <u>Harry Paul Ross</u>		M.D. 203 N. Queen St Chesertown, Maryland								
PHYSICIAN'S NAME (Type) <u>Harry Paul Ross</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20/59		22c. NAME OF CEMETERY OR CREMATORIUM Sharptown Cemetery		22d. LOCATION (City, town, or county) Rock Hall, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams					ADDRESS Chesertown, Md.		24a. REC'D BY REGISTRAR DATE APR 22 '59	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haas</u>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4456

CERTIFICATE OF DEATH

114448

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b 6 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Rock Hall		d. STREET ADDRESS Bratidue		
NAME OF HOSPITAL (If not in hospital, give street address) Or INSTITUTION Kent & Queen Anne Hosp						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Lost	4. DATE OF DEATH 4	Month	Day	Year
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1873		9. AGE, IN YEARS 86 yrs. (Not including birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Minister, Ret		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Madison		14. MOTHER'S MAIDEN NAME Nanice Chilton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO. —		17. INFORMANT Daughter - Wilmington Del.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Central Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 18 hrs				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) Advanced Age & Artherosclerotic						
(c) Arteriosclerotic disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rock Hall		(County) (State)
21. I certify that I attended the deceased from 4/4/59, 19, to 4/4/59, 19, that I last saw the deceased alive on 4/4/59, 19, and that death occurred at 12:05 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Rock Hall, Md		DATE SIGNED 4/6/59
ACTUAL SIGNATURE William M. Boutwood M.D.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/59		22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel		22d. LOCATION (City, town, or county) Rock Hall		(State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill		ADDRESS		24a. REC'D BY REGISTRAR FPR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4463

CERTIFICATE OF DEATH

04449
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle MANSHIP	Last MELVIN	4. DATE OF DEATH April	Month	Day 5,	Year 19 59
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 6, 1896	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier	10b. KIND OF BUSINESS OR INDUSTRY Bank	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13. FATHER'S NAME Charles M. Melvin	14. MOTHER'S MAIDEN NAME Annie Hessey
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT 212-03-8659 Mrs. Lillian P. Melvin, Millington, Md.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i>		
260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Decompression of the heart</i>		4 years
DUE TO (c) <i>Diabetes mellitus</i>		10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <i>Apr. 23, 1959</i> to <i>Apr. 5, 1959</i> that I last saw the deceased alive on <i>Apr. 5, 1959</i> , and that death occurred at <i>7:19 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Geza Koralewski</i>	M.D.	ADDRESS (Street, city or town, state) <i>MILLINGTON, MD</i>	DATE SIGNED <i>5-7-59</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 8, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery	22d. LOCATION (City, town, or county) (State) Millington Kent Co. Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows</i>	ADDRESS <i>Millington, Md.</i>	24a. REC'D BY REGISTRAR DATA APR 9 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4457

CERTIFICATE OF DEATH

Reg. Dist. No.

04450

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b Unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Rural	
3. NAME OF DECEASED (Type or print) Timothy C. Rasner		4. DATE OF DEATH Month: 4 Day: 27 Year: 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Rasner		14. MOTHER'S MAIDEN NAME Mary Sapp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 17. INFORMANT Step daughter - Chester town, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto May cerebral Infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/17</u> , 1959 to <u>4/27</u> , 1959, that I last saw the deceased alive on <u>4/27</u> , 1959, and that death occurred on <u>4/27</u> , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>William M. Satterfield</u> M.D. ADDRESS (Street, city or town, state) Rock Hall, Md DATE SIGNED <u>4/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/30/59	22c. NAME OF CEMETERY OR CREMATORIAL ELKTON
22d. LOCATION (City, town, or county) ELKTON, MARYLAND (State)		23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald M. Dees MD	
24a. REG'D BY REGISTRAR MAY 1, 1959		24b. REGISTRAR'S SIGNATURE Donald M. Dees	
VS A15 (4) 15M 9/55			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with Form PMA3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

W5. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
L.C. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Kent				a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Massey		size -		x Massey	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
				e. IS RESID. ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Female		Jo	ann	Shelton	April 11 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb 16, 1959	10 yrs. 26
10a. USUAL OCCUPATION (Give kind of work done during most recent working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Barg		Baby		Elkton Md.	
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Raymond Edward Shelton		Sybil Farris		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
(No, yes, give war or dates of service)				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		491X			
491X		DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		(Pending microscopic examination)	
DUE TO		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		4/11 1959	While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	Home	Massey Kent Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		DATE SIGNED			
ROBERT W. FARR		4/12/59			
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22d. LOCATION (City, town, or county) (State)	
Burial April 14 1959		Massey Cem.		Massey Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24. REC'D BY REGISTRAR	
Edward Ellour		Mullington Md.		Arthur S. Knut	
				DATE APR 17 '59	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon flap. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4458

CERTIFICATE OF DEATH

04452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
3. NAME OF DECEASED (Type or print) Charles H. Smith		d. STREET ADDRESS 1 318 Calvert St.	
4. DATE OF DEATH April 16, 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1899	
9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant		10b. KIND OF BUSINESS OR INDUSTRY prop.	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Smith		14. MOTHER'S MAIDEN NAME Hattie Woodland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-32-0644	
17. INFORMANT Bertha Smith		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14</u> , 1959, to <u>4/16</u> , 1959, that I last saw the deceased alive on <u>4/16</u> , 1959, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas J. Solon</i>		ADDRESS (Street, city or town, state) M.D. Chestertown	
PHYSICIAN'S NAME (Type) Thomas J. Solon		DATE SIGNED 4/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 19, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Janes Cem.		22d. LOCATION (City, town, or county) Chestertown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth Walker</i>		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE APR 21 '59		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Keane</i>	

DEPARTMENT OF HEALTH AND STATE SERVICES
STATE OF IDAHO

Physician _____
Signature _____
Date _____
Death certificate _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. LENGTH OF STAY IN lb 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S HOSP		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUDLERSVILLE	
3. NAME OF DECEASED (Type or print) CLAUDE FRANKLIN SMITH		First	Middle
4. DATE OF DEATH APR 23 1959	Month	Day	Year
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 29, 1905
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY - - -	
10c. BIRTHPLACE (State or foreign country) Md.		11. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OLIN S. SMITH		14. MOTHER'S MAIDEN NAME EFFIE LEAGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT HOSPITAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0		INTERVAL BETWEEN ONSET AND DEATH 3 weeks.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any: } (b) DUE TO RESECTION OF DUODENAL ULCER		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR 3, 1959 to APR 23, 1959 , that I last saw the deceased alive on Apr 23, 1959 , and that death occurred at 9:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>C. T. Keefe</i> M.D. PHYSICIAN'S NAME (Type) A. T. KEFFE, JR. M.D.		ADDRESS (Street, city or town, state) CHESTERTOWN, Md. DATE SIGNED 4-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 26	
22c. NAME OF CEMETERY OR CREMATORIUM Sudlersville		22d. LOCATION (City, town, or county) Sudlersville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR DATE APR 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Keefe	

STATE OF CALIFORNIA

CERTIFICATE OF DEATH

1923

1923

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